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Case 1:07-cv-07179 Document 27-3 08/20/2008 Page 2 of 32 **PLEASE** DO NOT STAPLE IN THIS AREA PICA ÀLTH INSURANCE CLAIM FORM MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP **FECA** 1a. INSURED'S I.D. NUMBER HEALTH PLAN (SSN or ID) BLK LUNG (SSN) (FOR PROGRAM IN ITEM 1) (Medicare --(Medicaid #) [ (Sponsor's SSN) (VA File #) 2. PATIENT'S LAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial) SEX JIMMY NULL MX F NULL, JIMMY 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) Self X Spouse Child Othe SAME 2.57 STATE S. PATIENT STATUS CITY 37472 INSURED INFORMATION Married X Other ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (INCLUDE AREA CODE) Employed X Full-Time Student Student 9. OTHER INS: RED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER a. OTHER INS. RED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) a. INSURED'S DATE OF BIRTH SEX YES X b. OTHER INS ED'S DATE OF BIRTH SEX b. AUTO ACCIDENT? PLACE (State) b. EMPLOYER'S NAME OR SCHOOL NAME MM DD YY F AND X NO VALLEY LINEN c. EMPLOYER NAME OR SCHOOL NAME c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME ENT TYES X NO PCN PREFERRED CARE NETWORK d. INSURANCE LAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES XX NO If yes, return to and complete item 9 a-d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize the release of any medical or other information necessary 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED SIGNED ON FILE 14. DATE OF CHRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM | DD | YY 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 10 97 17. NAME OF REPRING PHYSICIAN OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY 17a. I.D. NUMBER OF REFERRING PHYSICIAN DR. H.M. DI DEBARTOLO JR FROM TO O. OUTSIDE LAB? \$ CHARGES YES NO X 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 245 22. MEDICAID RESUBMISSION ORIGINAL REF. NO. 1. L 23. PRIOR AUTHORIZATION NUMBER В C DALES) OF SERVICE PAYS EPSD Place PROCEDURES, SERVICES, OR SUPPLIES Type of -DIAGNOSIS SUPPLIER INFORMATION (Explain Unusual Circumstances)
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Case 1:07-cv-07179 **PLEASE** DO NOT STAPLE IN THIS

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Filed 08/20/2008 Page 4 of 32 Document 27-3 HEALTHSTAF

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iz. FATIENT'S OR AUTHORIZED PERSON'S SIGNATURE is process this claim, raiso request payment of government rarew	ether to myself or to the party who ac	information necessary cepts assignment	payment of medical be services described be	enelits to the undersigned	physician or supplier for
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	O. BICACC DOLLER OF THE		2112 000	GRP#	J.A.

Case 1:07-cv-07179 Document 27-3 Filed 08/20/2008 Page 7 of 32 PLEASE DO NOT STAPLE IN THIS AREA PICA HEALTH INSURANCE CLAIM FORM PICA 1. MEDICARE MEDICAID CHAMPUS CHAMPVA FECA BLK LUNG (SSN) OTHER 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) HEALTH PLAN (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) 3. PATIENT'S BIRTH DATE 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) NULL, JIMMY F NULL, JIMMY 5. PATIENT'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 7. INSURED'S ADDRESS (No., Street) Self X Spouse Child SAME CITY STATE 8. PATIENT STATUS CITY STATE Single Married y Other ZIP CODE TELEPHONE (Include Area Code) ZIP CODE TELEPHONE (INCLUDE AREA CODE) Full-Time Part-Time Student Student 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO 11. INSURED'S POLICY GROUP OR FECA NUMBER INSURED a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (CURRENT OR PREVIOUS) a. INSURED'S DATE OF BIRTH YES F b. OTHER INSURED'S DATE OF BIRTH b. AUTO ACCIDENT? b. EMPLOYER'S NAME OR SCHOOL NAME
Suburban Teamsters of No. I1
Valley Linen PLACE (State) YES c. EMPLOYER'S NAME OR SCHOOL NAME c. OTHER ACCIDENT? c. INSURANCE PLAN NAME OR PROGRAM NAME P.C.N. Preferred Plan Network d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary payment of medical benefits to the undersigned physician or supplier for to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment services described below. ON FILE ON FILE SIGNED ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) 14. DATE OF CURRENT: 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION 04 15 97 GIVE FIRST DATE MM DD 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17a. I.D. NUMBER OF REFERRING PHYSICIAN 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY MM | DD | YY DR.H.M. DEBARTOLO, JR MM DD FROM TO 19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? \$ CHARGES YES ~ NO 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER С G H DAYS EPSDT PROCEDURES, SERVICES, OR SUPPLIES DATE(S) OF SERVICE To Place Type of SUPPLIER INFORMATION DIAGNOSIS (Explain Unusual Circumstances) RESERVED FOR OR DD CPT/HCPCS CODE \$ CHARGES Family Service EMG COB LOCAL USE UNITS 9000.00 197 1 04 | 15 PHYSICIAN OR 25, FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE XYES \$ 9000.00 \$9000,00 31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME ADDRESS, ZIP CODE & PHONE # INCLUDING DEGREES OR CREDENTIALS

(I certify that the statements on the reverse \_ 9 7 **EXHIBIT** 

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RENDERED (If other than home or office)

Delnor Community Hosp. 300 Randall Rd.

Geneva, Il., 60134

Dr. Hansel M. DeBartolo Jr Drive | Sugar Grove, Illinois 60554

Document 27-3 Case 1:07-cv-07179

cument 27-3, Filed 08/20/2008, Page 8 of 32
W. J. Haynes, I / 00695 HEALTH INSURANCE CLAIM FORM MEDICAID CHAMPUS CHAMPVA GROUP FECA BLK LUNG (SSN) OTHER 18. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) (VA FILE #) HEALTH PLAN Medicula #1 (Spansor's SSN) 1. Casa Parise First Name (Andle bullet) 3. PATIENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial) SEX NULL, JIMMY NULL, JIMMY and \$5 day streets 6. PATIENT RELATIONSHIP TO INSURED 7 INSURED'S ADDRESS (No., Street) Seed X Spanish SAME AS PATIENT will All STATE INFORMATION manned X Other: TELEPPERCOL INCLUDE AREA COOP ZIP CODE TELEPHONE (INCLUDE AREA CODE) Employed Full-Time Student Student 10. IS PATIENT'S CONDITION RELATED TO: eris (I) por como SiniAlaŭ mast Name, Fest Name, Midule Innano 11. INSURED'S POLICY GROUP OR FECA NUMBER STATE OF POLICY OF GROUP SIGNER INSURED a. EMPLOYMENT? (CURRENT OR PREVIOUS) a. INSURED'S DATE OF BIRTH SEX YES NO F a same sa sidin D AUTO AUGIDENT" D EMPLOYER'S NAME OR SCHOOL NAME PLACE (State) AND 4,4 INO VALLEY LINEN all on Stribul Minn CHIER ACCIDENTY .. INSURANCE PLAN NAME OR PROGRAM NAME ENT YES NO LUMBE OF PROCESS DAME PREFERRED 100 RESERVED FOR LOCAL USE PLAN O. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES XX NO HEAD BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. If yes, return to and complete item 9 a-d. 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I BURDOTZE - Fight is GR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary make, raiso request payment of government benefits either to myself or to the party who accepts assignment payment of medical benefits to the undersigned physician or supplier for services described below. ware ON FILE SIGNED ON FILE ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY LIME. Alto Del PREMITO DE ATEMITO 15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS.
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### Case Surbany-OFANSTERSOCHMANN ATERN ILEINOIS 8420/2008 WESSARS OF OFF

	s-,		CK NO: 1107863
FOR: Jimmy Mull	AMOUNT:	*1,310,40 CHE	
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Sugar Grove Il 605	1	NOT NEGO	TIABLE
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### SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & PAGE 40 FORD

FOR: Jimmy Null			AMOUNT:	编译字卷、译卷	CHECK NO:	1107864
DATE INCURRED: 03/10	/1997		整了整了。		ISSUE DATE:	0110786 <i>a</i> 04/ <del>32</del> /199
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FOR: Jinny Null	. *	AMOUNT:	\$6,000.00	CHECK NO: 🍶	10786
DATE INCURRED: 03/18/1997				ISSUE DATE:	01107866
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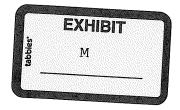
FOR: Jimmy Nall	w x *	AMOUNT:	\$445,40	CHECK NO:	10786
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	Employee	AGE A CLASS DE LA	DATESTOP TIME FROM: TOP 1	CHECK NO. 75 3C	HEGK AMOUNT \$ 4 4 5 PUNE CODE

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### Case 1:07-0-157491=3066umontziern illiheds08/20/2008 wEarn 13-9132

FOR: Jimmy Mull	AMOUNT:	* \$445.46	CHECK NO:	107869
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### Case 1:07-cv-07179 Document 27-3 Filed 08/20/2008 Page 14 of 32 SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

FOR: Jimmy No						
	ac.,	<i>₩</i>	AMOUNT:	*446 41	CHECK NO:	11.42
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by on text I have to be	***************************************			05/06/1997 0	1111425	\$446.4
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MEMBER NUMBER 2 PE LOCAL TEMPLOYERING

### Case 1:07-cv-07179 Document 27-3 Filed 08/20/2008 Page 15 of 32 CLAIMS OFFICE

7045 M. WESTERN AVENUE CHICAGO, IL 60645-3488 (312) 338-8500

CLAIM INFORMATION FORM Page

07/10/1997

ENROLLEE:

Jimmy Null

PATIENT:

Null, Jimmy

ACCOUNT: POLICY NO:

Suburban Teamsters Local 142

S.S. NO.: CLM NO:

PROCESSOR: Lisa Biegacz.

		KEEP THIS NO OTHE	STATEMENT FOR T	AX PURPOSES E PROVIDED		*IF CODE PRES	*IF CODE PRESENT SEE REMARKS BELOW			
ATURE OF			TOTAL	INELIGIBLI	E.	AMOUNT	<u> </u>			
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27 Adjustment payment to Usual & Customary Charges are over our usual and reasonable

Jimmy Null

YABLE TO		CHECKS ISSUED	AMOUNT	
01-7			AMOUNT	DATE
eBartolo MD, Dr H	•	Q1125045	1486.61	07/10/97
1 De Bartolo Drive			1700101	U1719771
			*	
ugar Grove Il	60554			





### Case 15 67 50 10 7 7 7 9 STED SCOMEN PROTHERN FILL MOOS / 215 / 2000 8 & Wages 166 of LAD

		. *		
	FOR: Siamy Mull	AMOUNT:	#1,486.61	CHECK NO: 1125045
	DATE INCURRED: 94/15/1997	PT#:		01125045 SSUE DATE: 07/10/1997
	PAYEE TAX IDENTIFICATION NO:		UNION NATIONAL	BANK
	PAY THE SUM OF 1,48 TO THE ORDER OF	6 DOLLARS 61 CENTS	& TRUST CO ELG PAY	IN, ILL.  AMOUNT OF CHECK  \$1,486.61
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### Case 1:07-cv-07179 Document 27-3 Filed 08/20/2008 Page 17-of 32 SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

. . . 5 FOR: Jimmy Null CHECK NO: 1115689 AMOUNT: \$446.40 DATE INCURRED: 04/21/1997 01.1-15689 PT#: ISSUE DATE: 05/22/1997 PAYEE TAX IDENTIFICATION NO: UNION NATIONAL BANK & TRUST CO, - ELGIN, ILL. S AMOUNT OF CHECK! PATHE ORDER OF 446 DOLLARS 40 CENTS \$446.40 PAY DOLLARS: DeBartolo MD, Dr H 11 De Bartolo Drive Sugar Grove 60554 NOT NEGOTIABLE AUTHORIZED SIGNATURE #1115689# 1071900993K #960m666#

### SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS HEALTH & WELFARE FUND

Jimmy Null	Employee	AGE GLASSER	05/22/1997 01115689	**************************************
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Case 1:07-cv-07179 Docuroent Ms-officted 08/20/2008 Page 18 of 32

7045 N. WESTERN AVENUE CHICAGO, IL 60645-3488 (312) 338-8500 = FAY: (312) 33

(312) 338-8500 = FAX: (312) 338-8995

Page: !

May 28, 1997

DeBartolo MD, Dr H 11 De Bartolo Drive

Sugar Grove Il 60554

Re: Claim No:

Claimant: Jimmy Null

Insured: Jimmy

Null

Group No: 1

Dear DeBartolo MD, Dr H

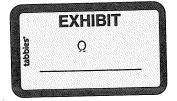
This is to advise you that the Claim Department for Suburban Teamsters is in receipt of your recent claim. However, before processing your claim, it is necessary that we request that you furnish us with additional information.

4/15/97 Dr H DeBartolo
PLease justify your fee of \$9000.00 for the above dated (see attached). The charge is considerably over our usual and customary.

You may be assured that as soon as the above requested information is received, we will give your claim immediate attention. If you have any questions, please feel free to contact our office.

Sincerely,

Claims Department





### DeBartolo Clinic

DeBartolo Clinic 11 DeBartolo Drive Sugar Grove, Illingis 60554

Phone: 630-859-1818 Fax: 630-859-1830 E-mail: debartolo@americamail.com

Wednesday, March 25, 1998

PCN 7257 N. Lincoln Ave LIncolnwood, IL 60646

Re: Jimmy Null

Dear Administrator:

We wish to formally protest the amount allowed for this surgery. More should have been allowed.

Should you have any questions, please contact Dr. DeBartolo, Jr. at the above address.

Thank you.

Sincerely,

H.M Dewartolo, Jr., M.D.,J.D.

EXHIBIT

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APR 17 1998

## HEALTH & WELFARE PLAN OF BENEFITS

PROVIDED BY THE

# SUBURBAN TEAMSTERS OF NORTHERN ILLINOI WELFARE FUND



### SUMMARY PLAN DESCRIPTION

BENEFITS IN EFFECT AS OF JANUARY 1, 1996



EIN: 36-6158494

EXHIBIT

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### DEFINITIONS

the feminine (she, her, hers) wherever it is required. Spouses are usually referred In this booklet, the use of a masculine personal pronoun (he, him, his) includes to in the feminine gender, but the masculine gender applies where applicable. Also, where the words "you" or "your" are used, it means an employee.

formed on patients on an outpatient basis. In order to be an approved ambulatory surgical center for the purposes of this Plan, it must meet all of the following requirements: (1) It must be licensed and supervised by a full-time M.D. and keep medical records on all patients; (2) It must employ a licensed anesthesiologist and a registered nurse, and the doctor who performs the surgery must also be allowed ing rooms and a recovery room, be equipped to take care of emergencies and AMBULATORY SURGICAL CENTER—A health care facility in which surgery is peroperating privileges at a local hospital; and (3) It must have at least two operathave an agreement with a local hospital to take patients who develop problems.

CALENDAR YEAR—The 12-month period starting on January 1 of any year and ending on December 31 of that year.

ment existing between an employer and a union which provides for contributions to the Fund as well as any extensions, amendments or renewals, or any such new COLLECTIVE BARGAINING AGREEMENT—Any applicable negotiated labor agreeabor agreement executed in the future. CONTRIBUTIONS—Payments made by a contributing employer to the Fund on behalf of its employees. COVERED; COVERED UNDER THE PLAN—A person is eligible to receive benefits under this Plan.

**COVERED EMPLOYMENT—**Work that you perform for a contributing employer for which the employer is required to make contributions to the Fund on your behalf.

tal and orthodontic care and treatment which are eligible to be considered for payment under the Plan, subject to the provisions, limitations and exclusions of the COVERED EXPENSES; COVERED MEDICAL EXPENSES—The reasonable and customary charges necessarily incurred by a covered person for medical, vision, den-

COVERED PERSON—An eligible employee and any person in his family or household who meets the definition of a dependent.

### DEPENDENT

- Your spouse, while not legally separated from you. If your spouse is a full-time active member of the military service or armed forces of any country or nation,
- κi
- she is not considered a dependent under this Plan. (See page 40 under COBRA Coverage for an exception to this rule.)

  Your unmarried child (see "Definition of Child" below):

  a. Who is less than 19 years old; or

  b. Who is age 19 but less than age 24, provided he is a registered full-time student in an accredited secondary school, college, or university or in 4 for the major portion of his support and maintenance; however, a child who is age 19 or older is not eligible for benefits for alcoholism, drug abuse, mental or nervous disorders, self-inflicted injury of orthodontic treatment; or vocational or technical trade school or institute and is dependent upon you
  - Who is age 19 or older and who is incapable of self-sustaining employed ment because he is disabled due to mental incapacity, mental retardations or physical disability. The coverage of such a child will be continued for as long as you are eligible and all of the following requirements are met:

    The child must have become disabled before becoming age 19 and must remain disabled; ပ
- port and maintenance (except to the extent that he is supported by another parent, is receiving governmental aid or assistance, or is that beneficiary of another trust);

  The child must meet the requirements of the definition of a child except for age; and The child must be dependent on you for the major portion of his sup-
- At the time the first claim is filed on behalf of the child, you must functionally proof, at no expense to the Plan, that the child was so disablest before becoming age 19. However, if the required proof includes physical examination of the child by a doctor, the Plan will pay for the by the Trustees (but not more often than once in a 12-month period of proof is requested but not received on or before the date set by the Trustees, the child's coverage will terminate on that date. ered beyond the date he becomes age 19. You must furnish proof of the child's continued disability from time to time thereafter if requested exam. If you do not provide the proper proof, the child will not be cov-

If a child works for a contributing employer and is eligible for benefits under this Plan as an employee, or if the child is a full-time active member of the military. service of any country, the child is not considered a dependent under this Plan. (See page 40 under "COBRA Coverage" for an exception to this rule.)

L.P.N.—A Licensed Practical Nurse.

plies, that are required, in the judgment of the Trustees based on the opinion of a or injury, must be appropriate according to standards of good medical practice patient under the circumstances; must not be solely for the convenience of the sidered medically necessary, the service, treatment or supply must be consistent with the symptoms or diagnosis and treatment of the condition, disease, sickness and be the most appropriate service or supply which can safely be provided to the MEDICALLY NECESSARY—Only those services, treatments, or supplies provided by a hospital, a doctor, or other qualified provider of medical services and supqualified medical professional, to identify or treat an injury or sickness. To be conpatient, the doctor, or the hospital; could not be omitted without adversely affecting the patient's condition or the quality of medical care; and is not experimental or investigative. MENTAL OR NERVOUS DISORDER—A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, including alcoholism, drug abuse and drug addiction, and regardless of any physiological or traumatic cause or origin of such condition.

Trustees and an employer who has a collective bargaining agreement with one of the participating Local Unions of this Plan whereby the employer agrees to make and the Trustees agree to accept contributions to the Fund on behalf of the employer's employees who are not members of the bargaining group. PARTICIPATION AGREEMENT—A written agreement between the

a physical or mental condition which completely prevents you from engaging in any occupation for wage or profit, which has existed for at least 9 or more con-PERMANENT AND TOTAL DISABILITY—A disability which you suffer as a result of secutive months; and which is presumably permanent. To be considered a permanent and total disability, the disability must be established to the satisfaction of the Trustees based upon competent medical evidence.

PLAN; BENEFIT PLAN-The Health and Welfare Plan of Benefits summarized in this booklet. PRE-EXISTING CONDITION—A sickness, injury, disease, or other physical or mental condition of an employee or dependent:

- of prescription drugs or medicines), during the six months immediately before That was diagnosed or treated by a doctor, or for which the employee or dependent received any medical care, services, or supplies (including the use the employee's or dependent's effective date of benefits; or
- That produced symptoms during the six months immediately before the employee's or dependent's effective date of benefits and those symptoms would have caused an ordinarily prudent person to seek medical diagnosis or reatment. κi

Pregnancy and pregnancy-related conditions of female employees and spouses of male employees which exist on their effective date of benefits are not included as pre-existing conditions.

R.N.—A Registered Graduate Nurse.

R.N.—A Hegistered Graduate Nurse.

BEASONABLE AND CUSTOMARY CHARGE—An amount determined by comparing a particular charge with the charges made for similar services and supplies in the locality concerned to individuals of similar age, sex, and condition. The result of this comparison will determine the amount that is the maximum allowable charge to be considered a covered expense under this Plan.

for room (semi-private rate) and board and general duty nursing care. This does not include any charges for professional services of doctors or private duty nurses or any charge for any individual nursing care, regardless of what it is called. ROOM AND BOARD CHARGES—All charges made by a hospital in its own behalt

SELF-PAYMENTS—Payments made to the Fund by you or your dependents or order to continue Plan coverage under the rules governing COBRA Coverage Payments that are remitted to the Fund by your employer on your behalf which are funded in whole or in part by payroll deduction are not considered self-pagements.

assist them to reach a degree of body functioning to permit self-care in essentiated daily living activities; it provides 24-hour-a-day supervision by one or more dock tors or one or more R.N.s, it provides 24-hour-a-day nursing services by licenselt nurses under the supervision of an R.N., and it has an R.N. on duty at least hours a day; every patient is under the supervision of a doctor, and it has available at all times the services of a doctor who is a staff member of a general hose pital; it maintains daily medical records on all patients, and it provides appropriate the following criteria: it is primarily engaged in providing inpatient skilled nursing-care, physical restoration services and related services for patients who are corevalescing from injury or sickness and who require medical or nursing care to SKILLED NURSING FACILITY—An institution, or a distinct part of an institution logicals; it has a utilization review plan; it has a transfer agreement with one on more hospitals; it is eligible to participate under Medicare; and it is not, other that alcoholics, a hotel, a place for the care and treatment of mental diseases or tubers which complies with all licensing and legal requirements and which meets all of incidentally, a place for rest, for custodial care, for the aged, for drug addicts, for methods and procedures for the dispensing and administering of drugs and bioculosis, or a similar institution.

TREATMENT FACILITY FOR ALCOHOLISM AND/OR DRUG ABUSE—A rehabilitation facility for the treatment of persons suffering from alcoholism and/or drug abuse or drug addiction. To be considered an approved treatment facility for the purpositation of Healthcare Organizations or meet certain requirements specified by the es of this Plan, the facility must be accredited by the Joint Commission on Accred-

- or hospital confinements the covered person is not supplies, required to pay for. Services, 38.
- 39. Charges incurred that would not have been made is this Plan did not exist.
- Services or supplies provided for or in connection with a radial keratotomy or any other type of surgical reshaping of the cornea for the purpose of enhancing vision. 40.

## Additional Exclusions and Limitations:

- The Plan will not pay benefits in excess of \$2,000 for charges incurred for treatment of a sickness or injury of your foster child if the child's condition, sickness or injury existed prior to the child becoming your foster child (as described in the "Definition of Child" on page 28),
- No Plan benefits will be payable under any specified Plan benefit or for a particular type of care or treatment once a covered person has already received Plan benefits totaling any applicable maximum benefit under that benefit or for that type of care and treatment during any stated time period.

situations for which no payment, or limited payment, is made. Basically, benefits The preceding list is not an all-inclusive listing of Plan conditions, limitations and excluded procedures, services or supplies. It is only representative of the types of are only payable under this Plan for the direct treatment of non-occupational accidental injuries and sicknesses.

## GENERAL PLAN PROVISIONS

your dependents up to but not to exceed the maximum benefit shown for each benefit on the Schedule of Benefits for each Class. Benefits are payable when the AYMENT OF BENEFITS — Benefits are payable individually for you and each of required forms have been provided by the Welfare Fund Office to the Contract Administrator.

dependents) unless you assign benefits. However, if a person who is your depenmay be payable to the dependent or, if the dependent is a minor, to the adult who All benefit payments will be made to you (even if the claim is for one of your dent is not a member of your household, benefits for treatment of such dependent has custody and care of the minor, unless benefits are assigned

To assign benefits, you or your spouse complete the assignment section on a claim form or complete an assignment form from your doctor's office, a hospital, etc. The bills will be sent directly to the Welfare Fund Office. The Contract Administrator will make payments directly to the hospital, doctor, etc. You are responsible for paying any amounts not paid by the Plan.

executor or administrator of the person's estate, to his surviving spouse, parenth child or children, or to any individual who, in their opinion, is entitled to the benefits. If the Trustees decide that a person is not physically, mentally, or otherwise capable of handling his business affairs, and no guardian has been appointed for him assumed the care and principal support of that process. assumed the care and principal support of that person. If the person dies before all amounts that are due have been paid, the Trustees may make payment to the

A charge for any service or supply will be considered to have been incurred on the date that the service was rendered or the supply was provided.

## NOTICE AND PROOF OF CLAIM — TIME LIMITS

- TICE AND PROOF OF CLAIM TIME LIMITS

  If you have a claim, you must notify the Welfare Fund Office within 90 days simple statement written to the Welfare Fund Office will satisfy this rule as long as you give identifying information about the person the claim is for you do not furnish notice within 90 days, your claim will not be endangered by you show that you provided notice as soon as it was reasonably possible. **.**
- nished to you within 15 days after the Welfare Fund Office has received notice of claim, you will be considered to have complied with the requirements for proof if you submit written proof within the time limits stated below, describing the person the claim is for, the injury, sickness or disability the claim is for, and As soon as your notice of claim is received by the Welfare Fund Office, your will be furnished with forms for filling **proof** of claim. If the forms are not furnished to you within 15 days after the Welfare Fund Office, you within 15 days after the Welfare Fund Office. any bills for treatment of the injury or sickness. તાં
- Your written proof of loss of time que to usadilly most to the proof of any days after termination of the period for which claim is made. Proof of any other loss (claim) must be furnished within 90 days after the date of the loss. If you do not provide proof of loss within these time limits, payment of your claim will not be endangered if you show that it was not reasonably possible to furnish the proof when required and the proof was furnished as soon as it. က်

RELEASE OF INFORMATION — You must provide the Welfare Fund Office or Concertract Administrator with any required authorizations for release of necessary infor N mation relating to any claim you have filed.

EXAMINATIONS — The Trustees have the right to have a doctor of their choice examine a claimant when and as often as they may reasonably require while a

hospital or medical records relating to a claim and to ask for an autopsy in the claim is being processed. The Trustees also have the right to examine any and all case of a death, provided an autopsy is not forbidden by law. FREE CHOICE OF PHYSICIAN — You will have free choice of any doctor who meets the Plan's definition of a doctor.

Workers' Compensation Law or Occupational Diseases Law or similar law. This Plan does not affect any requirement for coverage under any Workers' Compen-WORKERS' COMPENSATION NOT AFFECTED — This Plan is not in lieu of any sation Law or Occupational Diseases Law or similar law.

tions regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or adminispriate, decisions of those acting for the Trustees) in such matters are final and RUSTEE AUTHORITY AND RIGHT — Under the Plan of Benefits and the Trust Agreement creating the Welfare Fund, the Trustees or persons acting for them, such as a claim review committee, have sole authority to make final determinatrative rules adopted by the Trustees. Decisions of the Trustees (or, where approbinding on all persons dealing with the Plan or claiming a benefit from the Plan. If it is the intention of the parties to the Trust that such decision is to be upheld a decision of the Trustees or those acting for the Trustees is challenged in court, unless it is determined to be arbitrary and capricious. All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement to change them. The Trustees have the authority to increase, decrease or change benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of Plan participants and beneficiaries.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted you under the Plan are legally enforceable.

Trust Agreement, the Plan, or any questions concerning the acts and transactions of the Trustees or any other matter that affects the Plan will be determined under GOVERNING LAW — All questions pertaining to the validity or interpretation of the federal law, where applicable federal law exists.

legally responsible for paying those expenses, the Plan will not pay benefits on the claim unless the requirements of the Subrogation Rules stated below obligated to pay claims resulting from the acts of such a person or corporation) which is or may be found legally responsible to pay your medical expenses. The subrogation rules do not apply to payments made under your own insurance SUBROGATION — If you file a claim for medical expenses and a "third party" is are met. A "third party" is any person or corporation (or any insurance company

Subrogation Rules—If a third party is responsible for paying expenses for which you file a claim, the Plan will only pay benefits on the claim under the following conditions:

- You must sign a Subrogation Agreement as follows:
- You agree that you will repay the Plan the amount of benefits which the Plan pays on the claim out of any recovery of expenses you may make, and a,
  - You agree that, if the third party does not voluntarily pay you for the incurred expenses and you do not sue the third party for recovery of the expenses, the Plan has the right to sue the third party in your name to recover the amount it paid. In such a case, if there is a recovery or settlement, you agree that the Plan's expenses, costs and incurred attorney's fees will also be paid out of the recovery or settlement; and ς.
    - You agree not to assign to any other person your right to recover the amount of the incurred expenses. ပ
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- If the expenses are incurred by a minor dependent child, you or the childs legal guardian must sign the Subrogation Agreement on behalf of the childs of you make a recovery of incurred expenses and do not repay the Plan as you agreed to do when you signed the Subrogation Agreement, the Plan as file suit against you to recover expenses it paid on your claim. The Plan also has the right to reduce any future hands. has the right to reduce any future benefits you may be entitled to on claims for yourself and your dependents until the proper amount has been recovered by the Plan. က

4. The Plan will not expect repayment of more than the benefits it pays on the claim or more than the amount you receive in recovery.

Restoration of Recovered Benefits — If a person has a claim which is subjected plan apply toward all applicable maximum benefit limitations the same as benefits which are paid for non-subrogation claims.

the benefits it paid through subrogation, the amount of benefits recovered may benefits to certain maximum benefits. The following rules apply to restoration observed benefits: If the Plan pays benefits under the subrogation rules and recovers some or all of

- Recovered benefits will not be restored to benefit maximums that pertain to abspecific accident or injury specific accident or injury.
- Recovered benefits will be restored only to benefit maximums that are capped by lifetime, calendar year or other period of time limitations.
- A restoration will be effective on the date the recovery is received by the Plan. 0

though he were enrolled, whether or not he is actually enrolled. If you wanther information about Medicare enrollment, contact your local Social Security office (at least 30 days before your 65th birthday, if possible).

BENEFIT CREDIT 

a person has a benefit credit on his record from a previous claim (or claims), the Plan will pay his covered expenses on the next claim at 100% until his benefit credit is used up. A separate benefit credit record is kept for each Plan benefit and used only for claims incurred under that benefit. In other words, a benefit credit under the Major Medical Benefit could not be applied to benefits on a claim for Dental Benefit credit will be applied to charges incurred before the date the savings were realized by the Plan. Also, a benefit credit earned by one member of your the amount of savings is credited on that person's record as a "benefit credit." If If the Plan saves money on a claim for a person by using C.O.B. during a year,

Filed 08/20/2008 efit credits on a person's record are deleted and a new benefit record is started family may not be applied to a claim of another member of the family. Benefit credits are based on a calendar year. At the end of each calendar year, any benfor the following calendar year.

## CLAIM REVIEW PROCEDURE

When you have a claim, be sure to follow the proper claim filing procedures. If a claim is denied by the Contract Administrator in whole or in part, you will receive information needed to perfect your claim. You will also be given an explanation of the claim review procedure. Claims will be approved or denied within 90 days, unless additional time (up to 90 more days) is required, in which case you will be a written notice stating the specific reasons for the denial, the specific Plan provisions on which the denial is based, and a description of any additional material or

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ENROLLMENT IN MEDICARE — You and your spouse are each responsible for enrolling in Medicare Part A and Part B when eligible to do so. At present, there is no cost to you for Part A, which provides hospital benefits. Part B covers such items as doctors' services. The government makes a small monthly charge for

If the above rules still do not clearly show which plan should pay first, the plan that has covered the person (for whom the claim is filed) the longest period of time will pay first, the plan that has covered the person for the next longest period of time will pay second, and so on.

If you and your spouse are both covered as employees under this Plan,

covering the parent without custody pays third.

benefits for claims for your dependent children will be coordinated, sub-

ect to the above rules.

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custody (if not remarried) pays first and the plan covering the parent without custody pays second. If the parent with custody has remarried, that parent's plan pays first, the stepparent's plan pays second and the plan

### C.O.B. WITH MEDICARE

for a contributing employer who has 20 or more employees after you become FOR EMPLOYEES CONTINUING TO WORK AFTER AGE 65 — If you continue to work age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

are still working and eligible (regardless of your age), this Plan will pay its normal benefits for her before Medicare pays. If she is covered under her own plan, her If your dependent spouse is age 65 or older and eligible for Medicare while you plan will pay first, this Plan will pay second, and Medicare will pay last.

fer Medicare as your only health care coverage when you are age 65, contact the make such a choice, this Plan will continue to pay primary benefits for you (and its normal benefits for your spouse) as long as you stay regularly eligible. Contract Administrator (or your spouse should notify her own plan). Unless you You (and/or your spouse) can decline coverage under this Plan. If you do, Medicare will be your only health care coverage. If you and/or your spouse pre-

spouse is age 65 and eligible for Medicare, and if your employer has fewer than 20 employees, Medicare will be your primary provider of health care benefits and this Plan will be secondary. NOTE: If you to continue to work for a contributing employer after you or your

sons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), in most circumstances this Plan will pay its normal benefits on that person's claims before Medicare pays its benefits unless the Plan is legally allowed to pay after Medicare pays. FOR PERSONS UNDER 65 — If any covered person is entitled to Medicare for rea-

**CLAIM DENIALS** — A denial of benefits occurs when all or part of a claim is denied by the Contract Administrator after receipt of all information you provide in support of your claim. You have the right to request a review of the claim. **CLAIM REVIEW PROCEDURE** — To obtain a review of a claim after a denial of benefits, you must write a letter to the Board of Trustees requesting a review. State your reasons for requesting the review and attach any additional information that you think will help a favorable decision to be made on your claim. Your letter must be sent to the Board of Trustees within 60 days of the date the denial was mailed to your last known address

To file a request for review, send your letter to the:

Suburban Teamsters of Northern Illinois Welfare Fund 7045 North Western Avenue W. J. Haynes and Company Chicago, Illinois 60645 Board of Trustees

wise act for you. You and/or your representative can review materials in the You can legally authorize someone else to file your request for review and other-Fund's files that are related to your claim. You and/or your representative can submit written comments and other material to support your request for review.

information you have provided. You will be informed in writing of the Trustees' decision within 60 days of the date that you filed your request for review. (In unusual circumstances, up to an additional 60 days may be required.) The deci-The Trustees will review all of the material submitted with your claim, the previous action taken on the claim by the Contract Administrator, and the additional sion will state the reasons for the decision and include specific reference to the provisions of the Plan documents upon which the decision was based.

If your request for review concerns a matter covered by an insurance policy, it will be referred to the insurance carrier for review. You may not file legal action against the Plan to recover benefits until all of the proper claim review procedures have been followed.

See below for circumstances which may result in loss of eligibility or benefits.)

## CIRCUMSTANCES UNDER WHICH ELIGIBILITY FOR BENEFITS MAY BE DENIED OR LOST

- Failure to make a required COBRA self-payment to the Fund when it is due to sailure to convert your life insurance to an individual policy within 31 dae κi
- Failure to notify the Contract Administrator of a handicapped dependent child's handicap before the child becomes age 19. က်
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- 4. Failure by your employer to make contributions to the Fund on your behalf, and on behalf of your fellow employees.

  5. Failure to provide proof of claim within 90 days after the event on which claim is based, or failure to furnish, when requested, information or documents available to you when necessary to complete a claim.

  6. Failure to furnish required documentation when requested such as a marriage certificate, birth certificates, adoption papers, court orders, divorce decrees etc.

  7. Failure to continue working in covered employment.

  8. Termination of the Plan of Benefits by the Board of Trustees. ဖ်
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Other provisions covering termination of your eligibility and termination of your dependents' eligibility are stated in the "Eligibility" section on pages 45-46.

### CIRCUMSTANCES WHICH MAY RESULT IN DENIAL OR LOSS OF BENEFITS

The Trustees or their representatives are authorized to deny benefits. The follow a ing list outlines some circumstances or reasons that all or part of a person's claim by be denied by the Contract Administrator or that would some contract may be denied by the Contract Administrator or that would cause a person to lose

The person on whose behalf you filed the claim was not eligible for benefits on the date the expenses were increased. on the date the expenses were incurred.

- You did not file the claim within the Plan time limits. ٥i
- The expenses that were denied are not considered covered expenses under the Plan, or the expenses for which you filed the claim were not actually incurred 6
- benefit allowed for that type of expense during a stated period of time, for The person for whom the claim was filed had already received the maximum instance a calendar year maximum benefit, a lifetime maximum benefit, etc.
- Some other plan was primarily responsible for paying benefits on the expenses. 5
- No payment, or a reduced payment, was made because some or all of the expenses were applied against a deductible. Θ.
- the Plan to pay your claim and recover payment from the third party or his medical expenses were incurred, was responsible for paying the expenses and you did not sign the required Subrogation Agreement which would permit A third party, such as the driver of a car that caused an accident for which insurance company.
- The Plan of Benefits was terminated. ω.
- For Classes C and D, a non-PPO hospital was used and benefits were reduced by the additional deductible and paid only on a co-pay percentage 6

## **YOUR RIGHTS UNDER ERISA**

are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants As a participant in the Suburban Teamsters of Northern Illinois Welfare Fund, you shall be entitled to:

- Examine, without charge, at the Plan Administrator's office or the office of the ing insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as Board of Trustees and at other specified locations, all Plan documents, includdetailed annual reports and Plan descriptions.
- uments and other Plan information, including a complete list of the names and addresses of employers sponsoring the Plan, or information as to whether a Upon written request to the Plan Administrator, obtain copies of all Plan doc-

particular employer is a Plan sponsor and, if so, the employer's address. A

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this sum-S 8 9

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. Theopeople who operate your Plan, called "fiduciaries" of the Plan, have a duty to dolon operate your Plan, called "fiduciaries" of the Plan, have a duty to dolon operate your interest of you and other Plan participants and beneficiary so prudently and in the interest of you and other Plan participants and beneficiary ries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtainrights. For instance, if you request materials from the Plan and do not received them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim to benefits which is denied or ignored, in whole or in part, you may file suit in a \$100 money, or if you believe you have been discriminated against for asserting your \$200 mights, you may seek assistance from the 11 \$200 money. ing a welfare benefit or exercising your rights under ERISA. If your claim for a wel-Filed 08/20/2008 sider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive of the reason for the denial. You have the right to have the Plan review and recon-Administrator. If you have any questions about this statement or about your rights rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you have any questions about your Plan, you should contact the Plan under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

HOW TO READ OR GET PLAN MATERIAL - You can read the material listed in the before requesting material. If a charge is made, your check must be attached to your written request for the material. The Welfare Fund Office address and phone mal business hours. Also, copies of the material will be mailed to you if you send above section by making an appointment at the Welfare Fund Office during nora written request to the Welfare Fund Office. There may be a small charge for copying some of the material, so call the Welfare Fund Office to find out the cost number are shown on the inside front cover of this booklet.

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### RESTATED AGREEMENT AND DECLARATION OF TRUST

### CREATING THE

### SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND

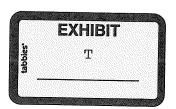
THIS RESTATED AGREEMENT AND DECLARATION OF TRUST, made and entered into this 127 day of 27 day of 1977, by and between LOCAL UNION NO. 179, LOCAL UNION NO. 330, LOCAL UNION NO. 423 and LOCAL UNION NO. 673, affiliated with the INTERNATIONAL BROTHERHOOD OF TEAMSTERS, CHAUFFEURS, WAREHOUSEMEN AND HELPERS OF AMERICA (hereinafter referred to as the "Unions") on behalf of all employee-beneficiaries hereof, the Employers obligated to make contributions to this Welfare Fund under the terms of Collective Bargaining Agreements, and HOWARD A. FLOYD, ROBERT VENARD, VINCE CRNKOVIC, JARL PETTERSEN, ERNEST R. LUDWIG, WALTER SCHOCK, RICHARD L. SCHIEK and PAUL LAMBRECHT, all of whom are presently all of the Trustees of SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND (hereinafter referred to as the "Trust"):

### WITNESSETH:

WHEREAS, the Unions and the Employers heretofore established a Trust for the purpose of providing and maintaining hospital, surgical and other health and welfare benefits for certain employees of the Employers and their beneficiaries, said Trust having been created on the 27th day of October, 1955 and amended from time to time thereafter, under the name of LOCAL #179 (Joliet, Illinois), LOCAL #330 (Elgin, Illinois) AND LOCAL #423 (Aurora, Illinois), I.B.T. WELFARE FUND, and the name of said Fund having been amended as of the first day of February, 1958, to be SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND; and

WHEREAS, the Unions have heretofore entered into Collective Bargaining Agreements providing that the Employers shall contribute to the Welfare Fund specified amounts of money on behalf of each employee covered by the said Collective Bargaining Agreements; and

WHEREAS, HOWARD A. FLOYD, ROBERT VENARD, VINCE CRNKO-VIC, JARL PETTERSEN, Employee Trustees, PAUL LAMBRECHT, ERNEST R. LUDWIG, WALTER SCHOCK and RICHARD L. SCHIEK,



the Trust for the direct payment of any benefits which have been contracted for by the Trustees in the case of the default of the insurance carrier or otherwise.

- 3.17 The Trustees may pay or provide for (1) the payment of all reasonable and necessary expenses of collecting the Contributions and administering the affairs of this Trust, including the employment of such administrative, legal, expert and clerical assistance that they determine to be necessary, (2) the leasing of such premises of the Trust, and (3) the purchase or leasing of such materials, supplies and equipment that the Trustees, in their discretion, find necessary or appropriate to the performance of their duties.
- 3.18 The Trustees shall have the power to construe the provisions of this Restated Agreement and Declaration of Trust and the terms and regulations of the Plan of Benefits; and any construction adopted by the Trustees in good faith shall be binding upon the Unions, the Employers, all parties dealing with the Trust and all persons claiming any benefits from the Trust.
- 3.19 The Trustees, by resolution, shall provide for fidelity bonds, in such form and amounts as may be required by statute, for their employees and for the Trustees who shall be authorized to handle assets of the Trust Fund. If no such statutory requirement shall exist, such bonds shall be in such form and amounts as the Trustees may determine. In addition, the Trust may by resolution purchase insurance for its fiduciaries and for itself to cover liabilities or losses occurring by reason of the act or omission of a fiduciary; provided, however, that such insurance policy shall be in the form and manner permitted by law.
- 3.20 The Trustees are authorized to extend the coverage of this Restated Agreement and Declaration of Trust to such other Employers as the Trustees shall agree upon, provided such Employers are required and agree to conform to the terms and conditions hereof and to make Employer Contributions pursuant to a Collective Bargaining Agreement with a Union.
- 3.21 The Trustees are authorized to negotiate, direct and agree to the merger of this Trust with, or into another

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### ARTICLE V

### Controversies and Disputes

- 5.01 In any controversy, claim, demand, suit at law or other proceeding between the Trustees and any employee-beneficiary or any other person claiming any benefits from the Trust, the Trustees shall be entitled to rely upon any facts appearing in the records of the Trust, any instruments on file with the Trustees, with the Unions or with the Employers, any facts certified to the Trustees by the Unions or the Employers, any facts which are of public record and any other evidence pertinent to the issue involved.
- 5.02 All questions or controversies of whatsoever character arising in any manner or between any parties or persons in connection with the Trust or the operation thereof, whether as to any claim for benefits, or whether as to the construction of the language of this instrument, the Plan of Benefits, or the rules and regulations adopted by the Trustees, or as to any writing, decision, instrument or accounts in connection with the operation of the Trust or otherwise, shall be submitted to the Board of Trustees for decision, and the decision of a majority of the Board shall be binding upon all persons dealing with the Trust or claiming any benefit thereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters.
- 5.03 The Trustees may, in their sole discretion, compromise or settle any claim or controversy in such manner as they think in the best interests of the Trust and its beneficiaries, and any decision made by the Board of Trustees in compromise or settlement of a claim or controversy, or any compromise or settlement agreement entered into by the Trustees, shall be conclusive and binding on all parties to the Trust, all persons dealing with the Trust, and all persons claiming any benefits thereunder.

such payment until a binding adjudication of such question or dispute, satisfactory to the Trustees in their sole discretion, shall have been made, or the Trustees shall have been adequately indemnified to their satisfaction against loss.

- 9.04 This Restated Agreement and Declaration of Trust shall be construed according to and be governed by the laws of the State of Illinois, except as may be provided by federal law.
- 9.05 Where used in this Restated Agreement and Declaration of Trust, words in the masculine shall be read and construed as in the feminine, and words in the singular shall be read and construed as though used in the plural, in all cases where such construction would so apply.
- 9.06 The Article titles are included solely for convenience and shall, in no event, be construed to affect or modify any part of the provisions of this Restated Agreement and Declaration of Trust or be construed as part hereof.
- 9.07 Should any provision of this Restated Agreement and Declaration of Trust be held to be unlawful, or unlawful as to any person or instance, such fact shall not adversely affect the other provisions herein contained or the application of said provisions to any other person or instance, unless such illegality shall make impossible the functioning of the Trust. No Trustee shall be held liable for any act done or performed in pursuance of any provisions hereof prior to the time such act or provision shall be held unlawful by a court of competent jurisdiction.
- 9.08 No person shall have any vested interest or right in the Trust Fund or in any payments from the Trust except as may be provided in any Plan of Benefits adopted by the Trustees, from time to time; provided, however, that the rights of any person who has become eligible for benefits hereunder by fully meeting the requirements of this Restated Agreement and Declaration of Trust or any Plan of Benefits created hereunder shall not be affected, changed, or altered by any amendment hereto, unless the Trust Fund, in the opinion of the Trustees, is inadequate to meet the payments due, in which event the Trustees shall determine whether such benefits shall be reduced uniformly or the Trust terminated.

IN WITNESS WHEREOF, the undersigned have caused this Restated Agreement and Declaration of Trust to be executed on the date first above written.

Howard A. FLOYD, Trustee

POPERT VENARD TRUCKS

VINCE CRNKOVIC, Trustee

JARL A. PETTERSEN, Trustee

RICHARD L. SCHIEK, Trustee

ERNEST R. LUDWIG, Trustee

WALTER SCHOCK, Trustee

PAUL LAMBRECHT, Trustee

UPON THE RECOMMENDATION OF:

Baren Transfer Co Employer Joeal Union 30. 330, International Brotherhood of Teamstern Local Union

By: Line Date

BY:

Date